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From the past and present to the future of psychoanalytic therapies in Germany

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Introduction

"Psychoanalysis has become part of our intellectual history though historical circumstances in Germany did lead to an interruption of this tradition. During the Third Reich, the works of Freud were inaccessible to most Germans, and the science he had founded was outlawed. Jewish psychoanalysts shared the fate of all Jews in Nazi Germany and the occupied territories of Europe."(Thomä & Kächele 1987, p. XVIII).

After the allied forces liberated Germany and Austriafrom Nazi terror, the future of psychoanalysis was near impossible to predict. No one would have assumed that 50 years later the psychoanalytic movement again would have spread throughout the German speaking parts of central Europe. In Austria, in Switzerland and in Germany[1] the present state of psychoanalysis as a clinical discipline reflects a long period of growth; the status of psychoanalysis as a theory of culture however is widely debated (Bruns 1994). In Germany the quantity of training available has been especially enlarged since the seventies when the decision was made to confide the job of training analyst to younger members as well[2]). At present the demand for psychoanalytic training too often finds its limitations in sheer quantitative restrictions of training facilities in the institutes[3] of the IPA affiliated German Psychoanalytic Association and in the non- IPA affiliated institutes (partially organized within the German Psychoanalytic Society- DPG[4] - or in the Deutsche Gesellschaft für

[1]Germany in this context reflects largely the developments in former West-Germany; in former East-Germany we cannot but speak of slow beginnings to re-establish psychoanalytic training, f.e. in Leipzig

[2]H.Thomä (president of the German Psychoanalytic association from 1968-1972) personal communication

[3]Berlin, Hamburg, Bremen, Köln, Düsseldorf, Giessen, Frankfurt, Heidelberg, Stuttgart-Tübingen, Ulm, München

[4] institutes in Berlin, Bremen, Hamburg, Hannover, Göttingen, Mannheim, Würzburg

Psychotherapie, Psychosomatik, Psychoanalyse und Tiefenpsychologie DGPT[5], and other more recently founded psychoanalytic groups of only local relevance[6]) throughout the country. The same holds true for Austria where the 27th International Congress of Psychoanalysis (1971) led to a change in the public opinion (Huber 1977) which stimulated the founding of new psychoanalytic study groups[7] beside the established Vienna Psychoanalytic Society.

This growth is embedded in the wider sphere of influence psychoanalysis has gained not only within medicine but also within the post war German-speaking culture. This is more clearly reflected by the the leading psychoanalytic journal "Psyche" selling 7000 copies each month. The topics of this journal cover not only clinical but also theoretical and applied psychoanalytic themes derived from fields of psychology, sociology, anthropology and philosophy (Kächele et al. 1993). Besides "Psyche" there are other flourishing psychoanalytic journals. Also from the fifties dates the empirically oriented "Zeitschrift für psychosomatische Medizin und Psychoanalyse" (Journal of psychosomatic Medicine and Psychoanalysis) which reflects in its publication policy the academic institutionalization of psychoanalytic oriented psychotherapy and psychosomatics. In 1985 when the IPA international congress tooks place in Germany for the first time after the war a new psychoanalytic journal was launched bridging in the editorship the quite substantial post-war cleft between the two psychoanalytic groups DPV and DPG. The "Forum der Psychoanalyse" hopes to re-unite the two psychoanalytic camps understanding the dissociation of psychoanalysis in post-war Germany as compromise and symptomformation (Ermann 1985, p.1). The growing awareness of psychoanalysis no longer being the sole object of Freud´ hagiographies paved the way for a journal devoted solely to the history of psychoanalysis (Luzifer-Amor: Zeitschrift zur Geschichte der Psychoanalyse, vol. 1, 1988).

A large number of books have appeared that underscore the reception of psychoanalysis in many intellectual quarters for which A. Mitscherlich was a true one man´s army (see the Freud centennial events organized by Adorno, Horkheimer and Mitscherlich in Frankfurt; Adorno, T. W. and W. Dirks, Ed. (1957). Though no longer as prevalent as in the seventies when the Frankfurt school of philosophy led by the marked leadership of Habermas (1971) and Lorenzer sha-

[5]like DGPT institutes in Berlin, München, Heidelberg, Köln
[6]like MAP in Munich
[7] institutes in Salzburg, Innsbruck, Graz and Vienna

ped the discussions (1970, 1974), it still continues on a smaller scale in cultural-philosophical discourse (Lorenzer 1986; Marquard 1987).

The evolution of the psychoanalytic oriented psychotherapy care system

Any relevant statement about the future of psychoanalysis in Germany that wants to go beyond the ivory tower perspective of pure psychoanalysis as a cultural theory (Adorno 1952), but wants to evaluate the transgenerational fertility of psychoanalysis as a clinical discipline, has to take into account the process of medical institutionalization of psychoanalysis in Germany. More than the anglo-american world struggling with the widening scope of psychoanalysis (A. Freud 1954) the German psychoanalytic movement in the immediate post war era was confronted with numerous consequences of the long years of isolation which became apparent after the war. Some of them were based on theoretical developments that boasted to be new and original - which they partially were[8](Schultz-Hencke 1951; see Thomä 1963, 1969) - which soon after the war led to a split in the psychoanalytic movement still operative today. Others were due to the urging necessities of caring for segments of the population that would not approach classical psychoanalysis even if it were available. Only in Berlin were these activities supported by the later Communal Health Insurance Company (Allgemeine Ortskrankenkasse); it marked " the first step in the recognition of neurosis as an illness by a German public institution in Germany. For the first time, one of the institutions in the social insurance system paid the cost of psychoanalysis and other psychotherapeutic treatment." (Dräger, 1971 p. 267).
After more than twenty years of dedicated clinical work the public health insurance organizations honoured the psychoanalytic contributions to the care of patients (see below). In our view this synergy between psychoanalysis and the public health insurance system reflects the great moral and intellectual impact that the psychoanalytic movement on the German post war society[9] has had and - so we predict - will continue to have in Germany even in the wake of behavioral medicine as new paradigm. For better or worse Freud´s 1919 Budapest manifesto has found a receptive society - a society that not only listened to the

[8]"Schultz-Hencke´s criticism of libido theory and metapsychology at the first post war congress of the International Psychoanalytical Association, held in Zurich, would today cause no sensation, and would actually be shared by many analyst" (Thomä & Kächele 1987, p.XX)

[9]Schulz, a well known and highly appreciated philosopher from the university of Tübingen located psychoanalysis under the chapter of ethics in his treatise on philosophy. He concludes that the impact of psychoanalysis is hard to underestimate: "Heute denkt fast jeder Gebildete mehr oder weniger in psychoanalytischen Kategorien " (1972, p.673)

voice of the intellect of Freudian theory but also followed Bismarck´s forced social security measures by regulating psychotherapy.

Another factor that has shaped the impact of psychoanalysis unto medicine resides in a tradition of an anthropological oriented psychosomatic approach to medicine. Von Weizsäcker´s Studies on pathogenesis (1935) mark the beginning of a cross fertilization between this philosophical oriented approach to medicine and psychoanalysis. His famous dictum that "psychosomatic medicine will be a psychoanalytic one or it will not be" has opened an inroad of psychoanalytic ideas that was most successful pursued by Thure von Uexküll and his collaborators (von Uexküll 1963, 1994). This melting of different strands of intellectual development into the establishment of a medical based field for the practice of psychoanalysis and its derived analytic psychotherapies may be not unique to Germany, but in its consequential course it seems to be quite special.

The beginning of this process in post war Germany can be traced by the establishment of quite a few institutions with a psychoanalytic orientation providing out -patient and in-patient treatments:

a) The Central Institute of Psychogenic Disorders (Zentralinstitut für psychogene Erkrankungen) in Berlin, supported by the local general insurance company (Versicherungsanstalt Berlin), established in 1946.
b) A psychosomatic-psychotherapeutic hospital for internal medicine, directed by Curtius was established in Lübeck in 1946
c) A special hospital for analytic psychotherapy in Göttingen 1949 by Kühnel and Schwidder.
d) The hospital for psychogenic disorders in Berlin established in 1948 by Wiegmann
e) 1950 a special ward for (private) patients was added to the university hospital for internal medicine in Hamburg by Jores
f) The Psychosomatic Hospital in Heidelberg established in 1950 by V. von Weizsäcker and A. Mitscherlich with the support of the Rockefeller Foundation
g) A few years later some more institutions were established at universities like in Freiburg (1957), Giessen (1962) and Mainz (1965).

Though all these institutions provided analytic psychotherapy and supported the development of psychoanalytic training institutes they were often termed "psychosomatic" so as to avoid interference with the psychiatrists that also claimed to provide psychotherapy.

A decisive change in the medical curriculum was achieved in 1970 when the training regulations (Ärztliche Approbationsordnung) now included besides medical psychology, medical psychology the new field called "Psychosomatic Medicine and Psychotherapy". This finally led to the institutionalization of full fledged independent university departments for psychosomatic medicine at 30 medical faculties. They were and still are all psychoanalytically oriented! However we expect a change in the very near future.

The development in the other part of Germany was quite different. Immediately after the second World War some analysts trained in the Berlin Reichs-Institut worked at the "Institut for Psychological Research and Psychotherapy". The impact of soviet medicine, especially of Pavlovian reflexology, led to a silent disappearance of psychoanalysis in the vocabulary of East-German psychotherapists (Geyer, 1992). In contrast to the direct state-imposed banishment of psychoanalysis under the Nazi-regime there was never an offical indictment of psychoanalysis. However the strict organization of societal rule in East-Germany made people become acute aware that psychoanalysis was not part of the cultural pattern of the German Democratic Republic.
The deficits were hardly compensated by private reading circles that began to work in the seventies only. In some church owned psychiatric hospital like the Psychiatrischen Bezirkskrankenhaus Uchtspringe, some interests in psychoanalytic topics were maintained (Geyer, 1989,1993), that inspired the training of practioners in Balint-group work.
The dominant figure of GDR-psychotherapy, R. Höck developed an amalgam of psychodynamics and social-psychology group therapy system that was successfully implemented in practically all of East-Germany out and in-patient facilities (Geyer, 1985,1989).
Soon after the fall of the Berlin wall exchange among east and west started with great enthusiasm and resentment from both sides at the same time. Meanwhile new local itraining institutes in Leipzig, Halle, Dresden & Rostock have been formed under the regulations of the insurance schema that we will describe below (Geyer 1992)..

The post-war evolution in Austria started in a quite similar way: Due to new theoretical viewpoints (i.e. Caruso, 1952) the psychoanalytic movement splitted after the end of the war, and in 1950, die Vienna Communal Health Insurance Company (Wiener Gebietskrankenkasse) started to pay for psychotherapeutic

treatment (Strotzka, 1969). The institutionalization of psychoanalytic psychotherapy in medical care developed slower, however: In 1971 the first and up to now the only institute for depth-psychology and psychotherapy was founded (with H Strotzka as chairman) at the psychiatry university clinic of Vienna, and from 1972 to 1979 a chair for psychoanalysis and clinical psychology with I. Caruso as head has been established at Salzburg university.
The impact of the 27th International Congress of the International Psychoanalytic Association (IPA) in 1971 also left its marks on the public opinion in Austria (Huber 1977) that only strengthened the position of the traditional Viennese Society but also instigated the established of non-IPA study groups in regional centers like Innsbruck and Graz.
The development of professional institutionalization shows some paralell to the German situation. In 1991 a law was established for regulation of the training of psychotherapists.More than a dozen of therapeutic orientations are accepted and membership in professional organizations may be acquired by many (s. Meyer et al. 1991). For this reasons psychoanalysists now are a real minority group among psychotherapists in Austria In 1995 out of 3633 recognized psychotherapeuts (55 per100 000 inhabitants) only 313 are fully trained psychoanalysts..

The German Psychotherapy Delivery System

The recognition of neuroses as illnesses (im Sinne der Reichsversicherungsordnung, see Faber 1981) was a precondition for the inclusion of the so-called standard psychotherapy in the program of the major health insurance companies in 1967, followed by other public organizations in 1971 (Haarstrick; Faber 1981).
Some limitations were imposed by the obligations of the public and private health companies. In Germany the health insurance system exists to enable the necessary outpatient and inpatient medical treatment at the time of need for people from all strata of society, regardless of their financial situation. Apart from a few special circumstances, the patient pays no more than his regular insurance premium (approximately 14% of his income). The legal constraints thus do not permit the health insurance companies to demand from the patient any direct contribution toward the costs of analytic (and today also of behavior) therapy. As nearly all patients consulting a psychotherapist in der FRG have medical insurance covering different forms of psychotherapy these regulations have a powerful impact on the psychotherapy service delivery system.

The system of providing psychotherapy is regulated by a set of agreements between the Kassenärztliche Bundesvereinigung (KBV; the national corporate organization of physicians regulating matters of public health and the payment of medical care) and the health insurance companies. The system of third-party payment is explicit about the fact that the patient makes no direct payment; instead he formally asks by way of the therapist writing a detailed report the KBV to cover the costs for treatment. A body of peer reviewers examines the claim and if positive the therapist recives his fee via the local branch of the KBV. However the patient does have a substantial monetary interest in this transaction, since he pays a fair proportion of his earnings to his health insuracne comapny as cover for general health care, including the eventuality of an illness whose costs would be too great for the average individual to pay alone. A typical person insured with one of these punblic companies pays about DM 5000.- (approximately $ 3125.-) annually. There are no further charges at time of use. It should be emphasized that the patient´s right of legal redress is directed not at the state but at the health insurance company, an arrangment dating back to insurance regulations implemented by Bismarck. The German social insurance system is supervised by the state, but it is not a national health service.

The patient knows how much is deduced from his salary or wages as his health insurance contribution, and he can caculate how much he has paid in over the years and how often he has availed himself of services, He has a free choice of doctor. Just as the public health insurance companies together form a corporate entity, nearly all doctors (and psychotherapists) are members of the KBV.

The fees for psychotherapists services as for all doctors´services are negotiated between these two corporate organizations. Obviously, the agreements on the fee rates for medical services involve compromises in which political factors play a part and the general economic situation must be considered. And indeed, in many respects, the specific regulations covering the analytic and behavioral psychotherapies, including the guidelines on payment, represent such a compromise.

Practitioners trained in psychoanalytic therapies are now in a position to offer the following kinds of treatments to their patients reaching 90% of the German population that are members of the general insurance system (based on Faber & Haarstrick 1989):

I Initial interview and evaluation	up to 6 sessions
II. Psychodynamic short term therapy	up to 25 sessions
III. Psychodynamic middle term therapy	up to 50 sessions
IV. Psychodynamic long term therapy	up to 80 sessions

V. Psychoanalytic therapy up to 300 sessions

Similar regulations are available for psychodynamic and psychoanalytic group therapy and special plans have been made for the treatment of children[10].

In recent years behavior therapies have also been included in these regulations.

The following figures on the numbers of physicians and psychologists trained in some more or less extensive way in psychoanalytic(oriented) therapies (the plural is mine !) practising with these insurance plans were cited by Meyer et al. (1991) for 1990:

Medical psychodynamic and -analytic therapists	3895
Psychological psychoanalysts	1237
Psychoanalytic child and adolescent therapists	740
candidates in the last years of training	1068
in addition there are	
Psychological behavior therapists	1360

The following graph represents the growth of the psychotherapy profession over the years 1982 until 1990:

Figure 1 about here

These practioners provide a mean density of care of 11.5 psychotherapists per 100,000 inhabitants; however no figures are available on the share of non-insurance licensed private financed analytic practice. For all our knowledge most of this deals with training activities of senior analysts as all groups have to undergo some amount of self-analysis or self -therapy[11]. However this statistical mean is composed of quite diverse regional levels of density of care: In Frankfurt there are 50, in Berlin 30 and in Saarland 5 per 100,000 inhabitants.

[10]For a more detailed description how the system works and for a discussion of its implications for the psychoanalytic process, see Thomä & Kächele 1987, chap. 6

[11]For physicians training for psychodynamic therapy 150 sessions are obligatory; for analytic candidates the length of training analyses varies between 500 and 1000 sessions (Kächele 1991).

An additional unique feature of the German psychotherapy delivery system has to be described. As our short historical account may have shown the beginnings of this psychoanalytic oriented field of psychotherapy was closely connected to providing inpatient facilities. As Schepank (1988) with many historical details makes clear this trend has been increasing since the seventies when large hospitals established for the treatment of chronic somatic diseases like tuberculosis had to find a new clientel: psychosomatic medicine turned out to be a comparatively cheap medicine and thus financially attractive for the owners of rehabilitation institutions. Figure 2 displays the steeply rising numbers of beds for psychotherapy /psychosomatics in the so called rehabilitation segment of medical care and the less pronounced growth of beds in ordinary hospitals (Lachauer et al. 1991):

Figure 2 about here

The more than 8000 beds for short term inpatient psychotherapy are officially provided for rehablitative aftercare for somatic conditions like cardiac, pulmonary, orthopaedic, dermatologic complaints etc. Given the large percentage of patients suffering from functional somatic complaints the system of inpatient rehabilitation has over the years transformed into a system of inpatient psychodynamic oriented psychotherapy; in recent years behavioral approaches also have successfully moved into that field and today about 25 % of the hospitals operate within a behavioral frame. Most of these inpatient facilities officially are still working under the adminstrative-financial regime of rehabilitation provide only up to six weeks of intensive multimodal psychotherapy. However some institutions are officially recognized as psychotherapeutic hospitals thus being able to provide quite intensive psychoanalytic inpatient treatments lasting up to nine months (f.e. Psychotherapeutic Hospital Stuttgart (Schmitt et al. 1993). The patients taking advantage of these inpatient care facilities tend to be more sick than an outpatient clientel and/or their motivation for change or to use a behavioral term, their illness behavior often would not led them to seek help as outpatients. Most often these are chronically ill psychosomatic and psychoneurotic patients who do need some form of integrated psychosomatic, holistic treatment. The problem of this inpatient system consist in the lack of systematic adaequate aftercare as these patients are admitted to the therapeutic institutions from all over Germany.

Though this system of care - wordwide unique in its extension per capita of the population - offers complementary treatments for a segment of the suffering population that otherwise clearly would be not cared for, for scientific reasons one has to raise the issue whether this system of inpatient care follows the bad strategy of treating patients too late and too often as inpatients. The scientific issue has not been settled whether it would be possible to treat all these patients as outpatients if the system of out patient care would be in a position to really draw these patient into treatments. Therefore Meyer et al´s (1991) opinion decrying it as a "mis-allocation of public means" (S.41) might be too strong a statement because the development of inpatient psychotherapy also represents an outgrowth of large public acceptance of psychotherapy and especially of psychoanalytic oriented psychotherapy (Kächele & Kordy 1992).

This is underscored by two recent developments in the institutional configuration of psychotherapy within the German medical system:

a) In 1987 a new tool to encourage general practitioners to use more psychological competence in their daily work with patients was introduced called "basic psychosomatic care". It demands a minimal training in psychodynamics to increase diagnostic competence and to add some therapeutic psychological interventions to the conditions of the daily practice. It is financially rewarding and seems to become a successful tool for raising the level of awareness to the needs of the many functionally disturbed patients. In 1989 already 23,000 practitioners used this new minimalistic medico-psychological device.

b) In 1993 a new specialty for psychotherapeutic medicine was created which will further enhance the historical process of generating the field of "psychosomatic medicine and psychotherapy" that began right after the war. Until then psychoanalytic therapies within medicine were based on mutual agreements that could be easily altered. With the establishment of a specialty field, besides and independent from psychiatry, a major breakthrough will have been achieved. Even if this field is not by definition a psychoanalytic specialty, the historical dominance of psychoanalysis within German psychotherapy makes it quite clear that the majority of "specialists for psychotherapeutic medicine" will be trained by psychoanalysts and some of them also will promote their own training to become full psychoanalysts. The historical blindsight of German psychiatry of denouncing psychoanalysis and factually of neglecting the practice of psychothe-

rapy[12] has led to the creation of a unique field. Ironically at the same time that this new specialty was established, German psychiatry has officially rediscovered that psychotherapy should be a routine part of psychiatric training; this resulted in an extension of the specialty title as well now called "psychiatry and psychotherapy". Most likely, that psychiatric training will orient itself towards the more cognitive-behavioral oriented treatment techniques or compromise for the new star at the horizon of short term treatments, for "Interpersonal Therapy" (Klerman et al. 1984). This alliance of "so called empirically based psychotherapies" with psychiatry in Germany constitutes also the major challenge to the psychoanalytic dominance in the field. The meanwhile grown-up field of clinical psychology establishes itself as a new profession in psychotherapy (Grawe 1993) and will thus become the major rival for psychoanalytic therapies.

During the most recent years the position of analytic psychotherapy has faced a limitation in terms of weekly frequency of sessions (Thomä 1994). Two and three times a week only are allowed within the insurance regulated system until a maximum of 300 sessions; four times a week analysis are only allowed for a limited period of time due to medical reasons. The lack of substantial scientific based evidence of the impact of sessions frequency on outcome shows repercussions (Grawe et al. 1994; Kächele 1994). However the psychoanalytic oriented treatments make up for the majority of insurance based treatments:

BRD 1994 cases treated within the insurance schema

Psychodynamic Psychotherapy		124 523
a) short-term (up to 40 sessions)	85 681	
b) long-term (up to 100 sessions)	38 842	
Analytic Psychotherapy (2-3 session per week)		29 435
Behavioral oriented Psychotherapy		98 532
a) short-term (up to 25 sessions)	65 117	
b) long-term (up to 80 sessions)	33 415	

The current main topic within the German psychotherapy care system is centered around the issue whether or not clinical psychologists trained in one of the

[12]In 1982 only "Psychotherapy in Psychiatry" became the official theme of a congress of German psychiatrists (Helmchen et al. 1982)

two legally accepted therapeutic orientations (psychoanalytic and cognitive-behavioral) should be given the status of independently working psychotherapists inside the medical system. Up to now each psychologist working as psychotherapist has to consult with a medical doctor on every case.. If the psychologist would be given an independent status a major inroad into the medical monopol of health care provioders would be achieved.

The outlook

As nothing is more difficult to predict than the future, the predictive power of any analysis has to be based on past performances. The story of psychoanalysis in post war Germany may be characterized as a process of slow but steady infiltration into the medical system. The Austrian development bypasses this step by establishing psychotherapy as a profession of its own in which psychoanalytic approaches also find their homes. A recent critical sociological study on the "civilized psychoanalysis" (Bruns, 1994) identifies three mechanisms how psychoanalysis became domesticized by mechanisms of power that were inherent in the western democratic societies. One of them resides in the relative success of the psychoanalytic treatment paradigm that we have described above for Germany and Austria. It certainly is true that the establishment of a healing profession with secure income tends to mitigate the fervour of its protagonists to critically analyzes that society that pays their fees. Even those critics who like to follow Parin & Parin-Matthèy (1983)´complaint of medicozentrism in psychoanalysis as a rule do not give up seeing patients from the general insuracne payment system. The exemption are those analysts like Parin working at the gold coast at the Zürich lake who are in a posotion to reserve psychoanalysis for private patients thus retaining a non-medical stance.
The real problem of this controversy resides in the question whether one wants to take serious the challenge that psychoanalysis had started out as an enterprise for private affluent people. And like other fortune-dependent cultural activties should be satisfied by tis state of affairs. Anyone deploring the process of medicalisation in germany and Austria should be aware of this implication.

Other people like to criticize the deplorable negligence of one of the shibboleths of psychoanalysis, of the"Kulturtheorie" (Nedelmann 1982). Once upon a time psychoanalysis started out besides being a clinical theory to become also a theory that critically analyzed the process of civilization. Now she has become

part of that civilization and thus became more and more unable to reflect upon itself. This process largely has been installed by the psychoanalystic groups themselves as Bruns (1994, p.153) points out. Whether this process has to do with the unablity of generations to maintain the spirit of its founder or whether the spirit of its founder has lost its magic power is an open question. From Freud´s two basic conceptions,. the drives and the unconscious, it seems to us that the drive theory has lost its teeth; quite on contrary to other, the unconscious, that still remains in the center of any enterprise that calls itself psychoanalytic. It may be that the concept of the unconscious has turned out to be much more powerful in its reach for many phenomena, be it clinical or cultural.

Therefore, our own position takes the view that the development of psychoanalysis as a scientific enterprise has been largely hampered by the situation in the psychoanalytic institutes (Thomä & Kächele 1987, p.35).
Psychoanalytic institutions have failed to maintain the inseperable bond between therapy and research. Freud´s legacy is passed on principally via the training of therapists, without any appreciable degree of systematic research or treatment in outpatient clinics, as foreseen in Freud´s model of how a psychoanalytic institute should function. Stagnation was thus built in, but was initially disguised by the unexpected expansion of psychoanalysis in the U.S.A. after World War II. The social acceptance of psychoanalysis motivated many young doctors to train as analysts. New training centers sprang up. Psychoanalytic concepts formed the basis of dynamic psychotherapy and psychiatry.
At first glance, therefore, it would seem obvious that the oft-bemoaned stagnation is due to "medical orthodoxy" (Eissler 1965) or to "medicocentric" training (Parin and Parin-Matthey 1983 a). On closer examination, however, this lightning diagnosis turns out to be merely a description of the symptoms, which is, moreover, based on the rather narrow conception of medicocentrism. It is more accurate to say that the goal of training has the same standardizing effect all over the world. Even in countries where training is open to laymen (including nonmedical academics), the institutions turn out psychoanalytic therapists. Specialization in the standard technique equips them to treat patients who are suitable for it.

It is an incontestable fact that almost all nonmedical psychoanalysts give up their previous profession; very few remain active in, or conduct interdisciplinary research from, their original academic discipline[13].
Thus it is the goal of training that imposes restriction and orthodoxy, which is unfairly tagged "medical." In all other areas of medicine, basic research is in fact encouraged, but the emphasis on practice in psychoanalytic training is labeled "medicocentrist."
General and specific questioning, including that in psychoanalytic research, break the chains of every kind of orthodoxy. In psychoanalysis, this leads to the cooperation with the humanities and social sciences. Freud underlined that

"alone among the medical disciplines, (psychoanalysis) has the most extensive relations with the mental sciences, and...it is in a position to play a part of the same importance in the studies of religious and cultural history and in the sciences of mythology and literature as it is in psychiatry. This may seem strange when we reflect that originally its only object was the understanding and improvement of neurotic symptoms. But it is easy to indicate the startingpoint of the bridge that leads over to the mental sciences. The analysis of dreams gave us an insight into the unconscious processes of the mind and showed us that the mechanisms which produce patological symptoms are also operative in the normal mind. Thus psycho-analysis became a depth-psychology and capable as such of being applied to the mental sciences..." (Freud 1923 a,pp. 252-253).

In the endeavor to treat the ill person adequately as a whole, medicine must draw on all sciences which could help to investigate, relieve, and cure human suffering. In this sense, the psychoanalytic method is one of many servants, and its master is not a specialist discipline, but rather the patient. More than the established disciplines, psychoanalysis has had (and still has) to fight for its right to determine its scope of activity and research and to work accordingly for the good of patients and society.
Psychoanalysis long remained one of the lesser servants, and Freud had to struggle to prevent it from being subordinated to a master, namely psychiatry. This hampered its practical and scientific development. Eissler (1965) welcomed the separation od psychoanalytic institutions from faculties of medicine and from univesities, but in fact this partition was one of the causes of the medical orthodoxy he bemoaned. Orthodox attitudes would have had no chance

[13]One of the honorable exceptions is the small group of nonmedical psychoanalysts who were qualified scientists before being trained under the auspices of the American Psychoanalytic Association. Favorable external circumstances have assisted most of this group of analysts to work productively in the area of interdisciplinary research and to sustain their competence in their original fields, to the benefit of psychoanalysis.

of surviving for long in scientific medicine. Of course, psychoanalysis has for good reason always been medicocentric, in the sense that therapeutic practice is its foundation- and the birthplace of its theory of culture. Scientific investigation in particular, demonstrates the interdisciplinary position of psychoanalysis and its dependence on exchange with the neighboring sciences. Psychoanalytic approaches can be applied productively in the humanities. However, all interdisciplinary cooperation also leads to relativization of the global claims made on behalf of psychoanalysis, whether as psychology or as theory of culture. In every psychanalytic institute or university where research groups have been formed in recent decades, ideologies of all sorts have been undermined (Cooper 1984; Thomä 1983).

The future

From these arguments we would predict that the development of psychoanalysis in Germany and Austria has a fair chance to fruitfully utilize the diversity of its institutionalization. Analysts working both in university departments and in psychoanalytic institutes care for a close collaboration; their roles are complementary and not always it is easy to reconcile the different tasks. However, the recent intellectual history of psychoanalysis has underlined the critical potential of those people working not only in private settings but also holding a job in public medical or psychological settings. Psychoanalysis in Germany and Austria will be in a position to utilize its academic potential, to engage in the deploringly lacking research on long term treatments (Bachrach et al. 1991; Kächele & Kordy 1993; Kächele & Thomä 1994) or to expand the necessary involvement in basic research (Dahl et a. 1988; Kächele et la. 1991). There they are faced with the new theoretical developments in emotion theory (Krause et al. 1988, 1992), with the challenge of the rise of cognitive science (Leuzinger-Bohleber et al. 1992), there they have to to face the manifolds issues of theoretical deconstruction and reconstruction (Carveth 1984; Thomä & Kächele 1987). The most exciting field of theoretical and clinical developments are taking place in the field of infant observation (Emde 1981, 1988). Changing models of infancy and the nature of early development will inevitably lead to a remodeling the foundation. The change of understanding of the individual development also casts new light on our understanding of the shaping of actual relationships. Attachment theory is about to become a major theoretical tool that brings about major revisions of Freud´s theorizing of the relationship of drives to social motivation (Silvermann 1991; Weiss 1991).

Psychoanalysts in Germany working most often as therapists, supervisors and teachers in the diverse clinical settings will be enriched by the large opportunities to discover new phenomenologies. Working as analysts also in the worlds of inpatient treatment facilities has taken up one of the very first psychoanalytic traditions to provide treatments settings for those that would not be reachable in a private practice (Schmitt et al. 1993); true this prevents the use of an overly restricted definition of what is psychoanalysis[14].
The true strength of psychoanalysis resides in its umbrella character, in its widened scope of application without loosing sight of its homeland, the psychoanalytic situaton.

Our optimism is grounded in the still vivid spirit of young analysts who come to psychoanalysis as an expression of a counter-culture. A. Mitscherlich (1966, 1967) and many others in the immediate post war period with the help of many psychoanalytic collegues from abroad re-created psychoanalysis as an engaged science that would use the tools of the psychoanalytic work to better understand humans and their suffering using Freud´s theories within medicine. The role of psychoanalysis as a theory to better understand the societal processes is more difficult to assess. The time for broad sweeping arm chair theorizing seems to pass away as too many of those conceptualizations have not really hold up to the promisses. To explain why Europe after successfull overcoming the post war cold war has plunged into an exacerbation of nationalism has very little to do with life or death instinct that were once so favoured in psychoanalytic circles. It may be that the concept of narcissism, the concept of the self and its vicissitudes - to paraphrase the title of a famous paper by Freud (1915c) - has a better survival value as an explanatory concept. The self has become a focus of attention from quite a diversity of philosophical and scientific points of view to mention Popper & Eccles (1977) discourse on te brain and the self, to include Banduras theory of self-efficacy leading to its application in psychotherapy (Cheshire & Thomä 1987).

[14]The reader may have noticed that we refrain from distinguishing true (IPA) psychoanalysis from other (non IPA) psychoanalysis. This is in line with our arguments in the textbook of psychoanalytic therapy (Thomä & Kächele 1987, 1992)

References

Adorno, T. W. (1952). Zum Verhältnis von Psychoanalyse und Gesellschaftstheorie. Psyche 6: 1-18.

Adorno, T. W. and W. Dirks, Ed. (1957). Freud in der Gegenwart. Frankfurt am Main, Europäische Verlagsgesellschaft.

Bachrach, H., R. Galatzer-Levy, et al. (1991). On the efficacy of psychoanalysis. J Am Psychoanal Ass 39(4): 871-916.

Bandura A. (1977). Self-efficacy: Toward a unifying theory of behavior change. Psychological Review. 84:191-215

Bräutigam W (1986) Zum Verhältnis von Psychiatrie und Psychoanalyse aus gegenwärtiger Sicht. In: Heimann H, Gaertner HJ (Hrsg) Das Verhältnis der Psychiatrie zu ihren Nachbardisziplinen. Springer, Berlin, S 47-54

Bruns G. (1994). Zivilisierte Psychoanalyse ? Soziologische Bemerkungen zu Selbstbehauptung und Anpassungsproblem. Zeitschr f psychoanal. Theorie und Praxis. 9:135-155

Carveth, D. L. (1984). The analyst´s metaphors. A deconstructionist perspective. Psychoanal Contemp Thought 7: 491-560.

Cheshire NM, Thomä H (Hrsg) (1987) Self, symptoms and psychotherapy. Wiley & Sons, New York Chichester

Cooper, A. M. (1984b). Columbia Center celebrates 40th anniversary. Am Psychoanal Assoc Newsletter 18(4): 10-15.

Cremerius, J. (1962). Die Beurteilung des Behandlungserfolges in der Psychotherapie. Berlin, Springer.

Dahl, H., H. Kächele, et al., Ed. (1988). Psychoanalytic Process Research Strategies. Berlin Heidelberg New York London Paris Tokyo, Springer.

Dräger, K. (1971). “Bemerkungen zu dem Zeitumständen und zum Schicksal der Psychoanalyse und der Psychotherapie in Deutschland zwischen 1933 und 1949.” Psyche 25: 255-268.

Eissler, K. (1965). Medical orthodoxy and the future of psychoanalysis. New York, Int Univ Press.

Emde RN. (1981). Changing models of infancy and the nature of early development. Remodeling the foundation. J Am Psychoanal Assoc 29:179-219

Emde RN. (1988). Development terminable and interminable. I. Innate and motivational factors from infancy. Int J Psycho-Anal 69:23-42

Ermann M. (1985). Editorial "Forum der Psychoanalyse". Forum Psychoanal. 1:1-3

Faber, F. R. (1981). “Der Krankheitsbegriff in der Reichsversicherungsordnung.” Psychother Med Psychol 31: 179-182.
Faber, F. R. and R. Haarstrick (1989). Kommentar Psychotherapie-Richtlinien. Neckarsulm-München, Jungjohann Verlagsgesellschaft.
Freud A (1954a). “The widening scope of indications for psychoanalysis. Discussion.” J Am Psychoanal Ass 2: 607-620.
Freud S (1915c) Instincts and their vicissitudes. SE vol XIV 109-140
Freud, S. (1919a). Wege der psychoanalytischen Therapie. GW Bd 12, S 181-194.
Freud, S. (1923a). "Psychoanalyse" und "Libidotheorie". GW Bd 13, S 209-233.
Grawe, K., R. Donati, Bernauer, F. (1993). Psychotherapie im Wandel: Von der Konfession zur Profession. Göttingen, Hogrefe.
Geyer M (1985) Das ärztliche Gespräch. VEB Verlag Volk und Gesundheit, Berlin
Geyer M (1989) Neuere Entwicklungen der Psychoanalyse und ihr Einfluß auf die Behandlungspraxis. Wiss. Z. Karl-Marx-Univ. Leipzig, Math.-nat.wiss. Reihe 38:394-407
Geyer M (1992) Zur Situation der Psychotherapie in der ehemaligen DDR. In: Tress W (Hrsg) Psychosomatische Medizin und Psychotherapie in Deutschland. Vandenhoek & Ruprecht, Göttingen
Habermas, J. (1971). Erkenntnis und Interesse. Frankfurt am Main, Suhrkamp.engl.: Knowledge and Human Interest. Boston, Beacon
Helmchen H, Linden M, Rüger U (Hrsg) (1982) Psychotherapie in der Psychiatrie. Springer, Berlin, Heidelberg, New York
Kächele H. (1989). Entwicklung und Beziehung im neuen Lichte. Prax Psychother Psychosom 34:241-249
Kächele, H. (1991). Lehranalyse in der DPV. im Auftrag der Deutschen Psychoanalytischen Vereinigung (nicht öffentlich).
Kächele H (1994) "An ihren Früchten sollt ihr sie erkennen." Bemerkungen zu Frequenz und Dauer der psychoanalytischen Therapie. Forum Psychoanal 10:352-355
Kächele, H., P. Döring, Waldvogel B., Eds. (1993). Psyche: Zeitschrift für Psychoanalyse und ihre Anwendungen. Gesamtregister der Jahrgänge 1947 bis 1992 (1-46). Stuttgart, Klett-Cotta.
Kächele, H., W. Ehlers, Hölzer M(1991). Experiment und Empirie in der Psychoanalyse. Perspektiven der Psychiatrie. Forschung-Diagnostik-Therapie. Stuttgart, Gustav Fischer.

Kächele, H. and H. Kordy (1992). Psychotherapieforschung und therapeutische Versorgung. Der Nervenarzt 63: 517-526.
Kächele, H. and H. Kordy (1993). Effektivät und Effizienz von hochfrequenten Langzeittherapien. Forschungsstelle für Psychotherapie Stuttgart.
Kächele H, Thomä H (1994) Psychoanalytic process research: Methods and achievements. J. Am Psychoanal. Ass . (in press)
Klerman, G. K., M. M. Weissman, et al. (1984). Interpersonal Psychotherapy of Depression. New York, Basic Books.
Krause, R. and P. Lütolf (1988). Facial indicators of transference processes within psychoanalytic treatment. Psychoanalytic process research strategies. Berlin Heidelberg New York London Paris Tokyo, Springer. 241-256.
Krause, R., E. Steimer-Krause, et al. (1992). Use of Affect Research in Dynamic Psychotherapy. "Two Butterflies on my Head..."Psychoanalysis in the Interdisziplinary Dialogue. Berlin, Springer-Verlag, p.277-291
Lachauer, R., H. Neun, et al. (1991). Psychosomatische Einrichtungen in Deutschland - eine Bestandsaufnahme. Göttingen, Verlag für medizinische Psychologie.
Lorenzer, A. (1970). Sprachzerstörung und Rekonstruktion. Vorarbeiten zu einer Metatheorie der Psychoanalyse. Frankfurt am Main, Suhrkamp.
Lorenzer, A. (1974). Die Wahrheit der psychoanalytischen Erkenntnis. Ein historisch-materialistischer Entwurf. Frankfurt am Main, Suhrkamp.
Lorenzer, A. (1986). Tiefenhermeneutische Kulturanalyse. Kultur-Analysen. Psychoanalytische Studien zur Kultur. Frankfurt am Main, Fischer. 11-98.
Leuzinger-Bohleber, M., H. Schneider, et al., Ed. (1992). "Two Butterflies on My Head..." Psychoanalysis in the Interdisciplinary Dialogue. Berlin, Springer-Verlag.
Marquard O (1987). Transzendenter Idealismus. Romantische Naturphilosophie, Psychoanalyse. Verlag für Philosophie. Köln
Meyer, A.-E., R. Richter, et al. (1991). Forschungsgutachten zu Fragen eines Psychotherapeutengesetzes. Universitätskrankenhaus Hamburg-Eppendorf.
Mitscherlich, A. (1966). Krankheit als Konflikt. Studien zur psychosomatischen Medizin, Bd 1. Frankfurt am Main, Suhrkamp.
Mitscherlich, A. (1967). Krankheit als Konflikt. Studien zur psychosomatischen Medizin, Bd 2. Frankfurt am Main, Suhrkamp.
Nedelmann, C. (1982). Zur Vernachlässigung der psychoanalytischen Kulturtheorie. Psyche 36: 385-400.
Parin, P. and G. Parin-Matthèy (1983). Medicozentrismus in der Psychoanalyse. Eine notwendige Revision der Neurosenlehre und ihre Relevanz für die Theo-

rie der Behandlungstechnik. Deutung und Beziehung. Kritische Beiträge zur Behandlungskonzeption und Technik in der Psychoanalyse. Frankfurt am Main, Fischer. 86-106.
Popper KR, Eccles JC (1977). The self and its brain. An argument for interactionism. Springer. Berlin Heidelberg New York
Schepank H (1988) Die stationäre Psychotherapie in der Bundesrepublik Deutschland: Soziokulturelle Determinanten, Entwicklungsstufen, Ist-Zustand, internationaler Vergleich, Rahmenbedingungen. In: Schepank H, Tress W (Hrsg) Die stationäre Psychotherapie und ihr Rahmen. Springer, Berlin, S
Schmitt, G., T. Seifert, Kächele H.(Eds). (1993). Stationäre analytische Psychotherapie. Stuttgart, Schattauer Verlag.
Schulz, W. (1972). Philosophie in der veränderten Welt. Pfullingen, Neske.
Schultz-Hencke, H. (1951). Lehrbuch der analytischen Psychotherapie. Stuttgart, Thieme.
Silvermann D. (1991). Attachment patterns and freudian theory: An integrative proposal. Psychoanalytic Psychology. 8:169-194
Thomä, H. (1963). “Die Neo-Psychoanalyse Schultz-Henckes. Eine historische und kritische Betrachtung.” Psyche 17: 44-128.
Thomä, H. (1983). The position of psychoanalysis within and outside the German university. Psychoanalysis in Europe. Bulletin of the Europ Psychoanal Fed 20-21: 181-199
Thomä, H. (1969). Some remarks on psychoanalysis in Germany, past and present. Int J Psychoanal 50: 683-692.
Thomä, H. and H. Kächele (1987). Psychoanalytic Practice. Vol 1 Principles. Berlin, Heidelberg, New York, London, Paris, Tokyo, Springer.
Thomä, H. and H. Kächele (1992). Psychoanalytic Practice. Vol. 2: Clinical Studies. Berlin, Heidelberg, New York, Paris, London, Springer.
Uexküll, T. v. (1963). Grundfragen der psychosomatischen Medizin. Hamburg, Rowohlt.
Uexküll, T. h., von, (Hrg) (1994). Psychosomatische Medizin, 5. Aufl. München Wien Baltimore, Urban & Schwarzenberg.
Weiss R (1991) The attachment bond in childhood and adulthood. In: Parkes C, Stevenson-Hinde J, Marris P (Hrsg) Attachment across life cycle. Tavistock, London, New York
Weizsäcker, V. v. (1935). Studien zur Pathogenese. Leipzig, Thieme.